

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G235 11-5-58 et

11730

## CERTIFICATE OF DEATH

11722

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANNE</u>		c. LENGTH OF STAY IN 1b <u>55 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PRINCESS ANNE</u>		e. STREET ADDRESS <u>MANSON ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>OLIN</u> Middle <u>HOYT</u> Last <u>BLOODSWORTH</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1903</u> <u>6-17-1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE BROKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SOMERSET CO. MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>PLUMMER BLOODSWORTH</u>		14. MOTHER'S MAIDEN NAME <u>ISADORE HORNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>214-32-7394</u>	
17. INFORMANT <u>WIFE, DOROTHY PRINCESS ANNE, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>CORONARY OCCLUSION</u> (c) <u>ATHEROSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 MINUTES</u> <u>11 11</u> <u>? YEAR 3</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>260X</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>52</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-1</u> , 19 <u>58</u> to <u>10-18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-7</u> , 19 <u>58</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George M. Dunn</u> M.D.		ADDRESS (Street, city or town, state) <u>PRINCESS ANNE, MD.</u>	
DATE SIGNED <u>10-20-58</u>			
PHYSICIAN'S NAME (Type) <u>GEORGE M. DUNN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/22/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Manokin Presbyterian</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Dunham</u>		24a. REC'D BY REGISTRAR <u>OCT 28 '58</u>	
ADDRESS <u>Princess Anne</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11731

CERTIFICATE OF DEATH

11723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Champ</b>			c. LENGTH OF STAY IN 1b <b>84 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Champ</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary V. Jennie</b> First <b>Bozman Sr.</b> Middle Last				4. DATE OF DEATH <b>Oct. 23</b> Month <b>19 58</b> Day Year			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25, 1874</b>		9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Thomas Shores</b>				14. MOTHER'S MAIDEN NAME <b>Frances Hall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs Beauchamp Bloodsworth Champ, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio-Vascular Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>10 yrs.</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>			20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June</b> , 1955, to <b>Oct 23</b> , 1958, that I last saw the deceased alive on <b>Oct 23</b> , 1958, and that death occurred at <b>5:10 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B. Frank Giganti</b> M.D.			ADDRESS (Street, city or town, state) <b>20 Prince William St</b> DATE SIGNED				
PHYSICIAN'S NAME (Type) <b>B. FRANK GIGANTI</b>			<b>Princess Anne Md</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>10-26-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oriole Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oriole, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Levin R. Wilson</b>				ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 2 8 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

CERTIFICATE OF DEATH

Date of Death OCTOBER 10, 1957		Decedent's Name THOMAS J. HUGHES	
Sex Male		Race White	
Date of Birth OCTOBER 10, 1907		Place of Birth BALTIMORE, MARYLAND	
Usual Residence 1001 N. W. 10th St. Baltimore 12, Md.		Present Residence 1001 N. W. 10th St. Baltimore 12, Md.	
Cause of Death Myocardial Infarction (Heart Attack)		Date of Death OCTOBER 10, 1957	
Place of Death Home		Signature of Physician [Signature]	
Signature of Registrar [Signature]		Signature of Medical Examiner [Signature]	
Date of Registration OCTOBER 10, 1957		Date of Medical Examination OCTOBER 10, 1957	
Registrar's Office Baltimore Health Department		Medical Examiner's Office Baltimore Health Department	

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11732 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11724

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u>		c. LENGTH OF STAY IN 1b <u>X Westover</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		e. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Collins</u> Last <u>Collins</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 23, 1900</u>
9. AGE (in years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Labor</u>	
11. BIRTHPLACE (State or foreign country) <u>Westover</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Collins</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Fooks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Lemistine Collins</u>		Address <u>Marion St., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Died suddenly</u> (c), stating the underlying cause last, (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>0</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. H. Johnson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Oct 11-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 12, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Westover</u>		22d. LOCATION (City, town, or county) (State) <u>Westover Som. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u>		ADDRESS <u>Marion St., Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knease</u>	

MEDICAL CERTIFICATION

2



FOR STATE  
HEALTH DEPT

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Death occurred about 11:00 a.m.  
at his residence

R. A. Johnson  
Rt. Johnson

Cell 11-22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11733

## CERTIFICATE OF DEATH

Reg. Dist. No.

11725

1. PLACE OF DEATH o. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>				c. LENGTH OF STAY IN 1b <b>Life Time</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRANKLIN</b> Middle <b>DASHIELDS</b> Last <b>DASHIELDS</b>				4. DATE OF DEATH Month <b>10</b> Day <b>20</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8.4/1889</b>	9. AGE (In years last birthday) yrs. <b>69</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Term</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>FRANKLIN DASHIELDS</b>				14. MOTHER'S MAIDEN NAME <b>MARTHA JONES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>CHARLES DASHIELDS PRINCESS ANNE, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>5 yrs.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 10, 1958</b> , to <b>Oct 20, 1958</b> , that I last saw the deceased alive on <b>Oct 18, 1958</b> , and that death occurred at <b>7:50 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B. Frank Giganti</b>				ADDRESS (Street, city or town, state) <b>20 PRINCEWILLIAM ST. PRINCESS ANNE, MD.</b>			
PHYSICIAN'S NAME (Type) <b>B. FRANK GIGANTI</b>				DATE SIGNED <b>Oct 21, 1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10/26/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT HOPE</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCESS ANNE, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WILLIAM H. JAMES JR.</b>				ADDRESS <b>PRINCESS ANNE, MARYLAND</b>		24a. REC'D BY REGISTRAR <b>OCT 27 58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur J. James</b>			

# CERTIFICATE OF DEATH

11733

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

DATE OF DEATH

DECEMBER 1964

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11734

## CERTIFICATE OF DEATH

11726

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WICOMICO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMO. HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>REGINALD</b> Middle <b>ALFONSO</b> Last <b>HORSEY</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>16</b> Year <b>19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-23-1957</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(INFANT)</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>10</b> Months <b>23</b> Days <b>23</b> Hours <b>23</b> Min.
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEONARD HORSEY</b>		14. MOTHER'S MAIDEN NAME <b>LENA COLLINS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT <b>LENA HORSEY</b> Address <b>FRUITLAND, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Food poisoning - 049.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 15, 1958</b> to <b>Oct 16, 1958</b> , that I last saw the deceased alive on <b>Oct 15, 1958</b> , and that death occurred at <b>9 a. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Sarah M. Peyton</b> M.D.		ADDRESS (Street, city or town, state) <b>33 W. Main St - Crisfield, Md</b> DATE SIGNED <b>Oct. 16, '58</b>	
PHYSICIAN'S NAME (Type) <b>SARAH M. PEYTON, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>OCT 18-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Westover</b>	22d. LOCATION (City, town, or county) (State) <b>Westover Somerset Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Ward</b> ADDRESS <b>Marion Md</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 21 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

2082193xvi

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, the registrar shall file it with the health department. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the registrar. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WAC 100-100-100  
TAM BOMID

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
11754  
CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. BOMID		2. SEX Male	
3. AGE 45		4. DATE OF BIRTH 1910	
5. PLACE OF BIRTH New York, N.Y.		6. OCCUPATION Carpenter	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1935	
9. NAME OF SPOUSE Mary J. BOMID		10. DATE OF DEATH 1955	
11. PLACE OF DEATH Home		12. CAUSE OF DEATH Heart Disease	
13. MANNER OF DEATH Natural		14. SIGNATURE OF PHYSICIAN J. J. BOMID	
15. SIGNATURE OF REGISTRAR J. J. BOMID		16. SIGNATURE OF WITNESS J. J. BOMID	

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11727

Reg. Dist. No.

11735

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>McCready Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>First OLIVER Middle - Last JONES</b>		4. DATE OF DEATH Month <b>October</b> Day <b>2</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 6, 1939</b>
9. AGE (In years last birthday) <b>19 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Marion, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Jones</b>		14. MOTHER'S MAIDEN NAME <b>Martha Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-36-2497</b>	
17. INFORMANT <b>John Jones, Marion Station, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull</b> DUE TO (b) <b>Automobile accident</b> Conditions, if any, which gave rise to immediate cause (c) <b>Automobile accident</b> DUE TO (c) <b>Automobile accident</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION (a) <b>Automobile accident</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Patient was passenger in automobile crash at high speed</b>	
20c. TIME OF INJURY Month, Day, Year <b>11:40 p.m. Sept 30, 1958</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Marion, Somerset, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William H. Coulbourn, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William H. Coulbourn, M. D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/5/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Georgetown Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 6 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11733

Name of Deceased		Sex		Age	
John Doe		Male		45	
Residence		Occupation		Cause of Death	
123 Main St, Baltimore, Md.		Teacher		Heart Disease	
Date of Death		Time of Death		Place of Death	
Jan 15, 1950		10:30 AM		Home	
Physician		Medical Examiner		Manner of Death	
Dr. J. Smith		Dr. J. Smith		Natural	
Signature of Physician		Signature of Medical Examiner		Remarks	
[Signature]		[Signature]		No autopsy performed.	
Date of Report		Time of Report		Place of Report	
Jan 16, 1950		11:00 AM		Baltimore, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11736

## CERTIFICATE OF DEATH

11728

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Crossfield</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Lawsen</u> Last <u>Lawsen</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 7 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George P. Tyler</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Jane Sterberg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>5 years</u> <u>5 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1</u> , 1958, to <u>Oct 8</u> , 1958, that I last saw the deceased alive on <u>Oct 8</u> , 1958, and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sarah M. Peyton</u> M.D.		DATE SIGNED <u>10/14/58</u>	
PHYSICIAN'S NAME (Type) <u>Sarah M. Peyton</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/11/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sunnyridge</u>		22d. LOCATION (City, town, or county) (State) <u>Crossfield Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Hannon</u> ADDRESS <u>Prince Anne Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Huns</u> DATE <u>OCT 21 1958</u>	





**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11729

Reg. Dist. No.

11737

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover</b> c. LENGTH OF STAY IN lb  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover</b> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Methvin</b>				4. DATE OF DEATH Month Day Year <b>Oct. 6 1958</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18, 1891</b>	9. AGE (In years last birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>cloth.</b>		11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Luther Methvin</b>				14. MOTHER'S MAIDEN NAME <b>Anne Jane Templeton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT Address <b>Mrs Virginia Methvin Westover, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary heart disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Died while sleeping</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.H. Johnson</b> EXAMINER'S NAME (Type) <b>R.H. Johnson</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Oct 9, 1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>Oct. 8, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Andrew Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Levin Wilson Princess Anne, Md.</b>				24a. REC'D BY REGISTRAR <b>OCT 10 '58</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

ILLNESS

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

DATE OF DEATH

DATE OF BURIAL

DATE OF INTERMENT

DATE OF CREMATION

DATE OF DISPOSITION

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

Death certificate is being  
sent to the funeral home

52 PM 5-10-12

W. H. Johnson  
no 8 x 10 1/2

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11728

## CERTIFICATE OF DEATH

11730

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>Crisfield</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Somerset</u>	
c. LENGTH OF STAY IN 1b <u>78 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>Crisfield</u>		39	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>10 S. 4th St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>J.</u> Last <u>Palmer</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1880</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Crisfield</u>	
13. FATHER'S NAME <u>Kellam Jewett</u>		14. MOTHER'S MAIDEN NAME <u>Unknown.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>217-01-4600-A</u>		17. INFORMANT Address <u>Mrs. M. Tilda F. Harrison - 10 S. 4th St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripartur Vascular Collapse</u> 570.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acidosis &amp; Dehydration</u> DUE TO (c) <u>Mechanical Pleur, Unknown Etiology</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>3 weeks</u> <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Arteriosclerotic Disease, Senility</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 16</u> , 19 <u>53</u> to <u>Oct 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 7</u> , 19 <u>58</u> , and that death occurred at <u>9:40 P.</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>A.N. Barr, M.D.</u>		ADDRESS (Street, city or town, state) <u>Crisfield, Md.</u>		DATE SIGNED <u>10/9/58</u>	
PHYSICIAN'S NAME (Type) <u>A. N. BARR, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 14/58</u>	22c. NAME OF CEMETERY OF CREMATORY <u>Lawsonia</u>	22d. LOCATION (City, town, or county) (State) <u>Crisfield, Som. Co., MD.</u>		
23. BURIAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u>		ADDRESS <u>Marion St., Md.</u>	24a. REC'D BY REGISTRAR DATE <u>OCT 14 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1928

County

City

Decem 1928

Christie

18 yrs

to 24th St

1928

April 15, 1880

U.S.A. Christie

Dark brown

1928-1929

Charles H. Ward  
Christie, S. Co. Md.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11738

CERTIFICATE OF DEATH

Reg. Dist. No.

11731

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>B.</b> Last <b>Powell</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>10</b> Year <b>1958</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 25, 1885</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trucking</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Rufus Powell</b>				14. MOTHER'S MAIDEN NAME <b>Mary Cary</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-12-4276</b>		17. INFORMANT <b>Mr. Elwood Powell Princess Anne, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>502.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio-Vascular Disease</b> DUE TO (c) <b>Chronic Bronchitis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 Minutes</b> <b>4 yrs</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema -</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June</b> , 1954, to <b>Oct 10</b> , 1958, that I last saw the deceased alive on <b>Oct 10</b> , 1958, and that death occurred at <b>11:40 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B. Frank Giganti</b>				ADDRESS (Street, city or town, State) <b>20 Prince William St Princess Anne Md.</b>			
PHYSICIAN'S NAME (Type) <b>B. FRANK GIGANTI</b>				DATE SIGNED <b>Oct 11, 1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10-11-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Manokin Presbyterian</b>		22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leon Wilson</b>				ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 15 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



11739

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Crisfield</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>McCreedy Hospital</u>		d. STREET ADDRESS <u>R.F.D. #1</u>	
3. NAME OF DECEASED (Type or print) <u>Boulak Jane Sterling</u>		4. DATE OF DEATH <u>Oct 28 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15 1883</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Walker</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Hamburg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Otis Riggins</u>		Address <u>Crisfield Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO (c) <u>Hypertension and arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>5 yrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 21</u> , 19 <u>58</u> , to <u>Oct 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 27</u> , 19 <u>58</u> , and that death occurred at <u>3 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sarah M. Peyton</u> M.D. <u>3321 Main</u>		DATE SIGNED <u>Oct 29, 1958</u>	
PHYSICIAN'S NAME (Type) <u>Sarah M. Peyton</u>		<u>Crisfield Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10/30/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lunenburg</u>	22d. LOCATION (City, town, or county) (State) <u>Crisfield Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Hixman</u>		24a. REC'D BY REGISTRAR <u>NOV 5 '58</u>	
ADDRESS <u>Crisfield Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hixman</u>	

CERTIFICATE OF DEATH

11-23-30

Decemr

Decemr

to be buried

Life

Travel & Burial

Not Ready to be Buried

7-12-31

Traveler

from

James White

James White

Thomas

Not

William

William

Not

Not to be Buried

James White 12/30/30 Buried

Travel & Burial

1

8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11733

11740

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>77 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMORIAL HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MANIE NELSON STERLING</b>		4. DATE OF DEATH <b>OCTOBER 21 1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 8, 1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR: Months <b>7</b> Days <b>19</b> Hours <b>58</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN LAWSON</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET DAUGHERTY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>ELVA CHRISTY, CRISFIELD, MARYLAND</b>	
17. INFORMANT <b>ELVA CHRISTY, CRISFIELD, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock, Wound, Cont. Dis.?</b> <b>733x</b> DUE TO <b>Fract R. Femur Pathologic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Osteo Pyrosis</b> DUE TO <b>Osteo Pyrosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>General Arterio Sclerosis, Hypertension, Chronic Kidney Disease</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fallen on floor at her home</b>	
20c. TIME OF INJURY Month <b>10</b> Day <b>16</b> Year <b>58</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <b>Home</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Crisfield</b> (County) <b>Somerset</b> (State) <b>MD</b>	
21. I certify that I attended the deceased from <b>10-16</b> 19 <b>58</b> , to <b>10-21</b> 19 <b>58</b> , that I last saw the deceased alive on <b>10-20</b> 19 <b>58</b> , and that death occurred at <b>3:45 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>MARION, MARYLAND</b> DATE SIGNED <b>George C. Coulbourn</b>			
ACTUAL SIGNATURE <b>George C. Coulbourn</b> M.D.		PHYSICIAN'S NAME (Type) <b>GEORGE C. COULBOURN, M.D., MARION, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/23/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lunenburg</b>		22d. LOCATION (City, town, or county) <b>Crisfield</b> (State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Herman Princes</b> ADDRESS <b>Marion, Maryland</b>		24a. REC'D BY REGISTRAR <b>OCT 29 1958</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G235 10-28-58 et

11741

CERTIFICATE OF DEATH

11734

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Dorchester Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James H. Telghman</u> First Middle Last				4. DATE OF DEATH <u>Oct. 19 1958</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/14/1874</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>MD Vernon Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Julia Strickland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-10-1063 A</u>		17. INFORMANT <u>John Sanford</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Disease</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>19 days</u>  <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive cardiovascular disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10-1-58</u> , 19 <u>58</u> , to <u>10-19-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-19-58</u> , 19 <u>58</u> , and that death occurred at <u>10P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>10-20-58</u>							
ACTUAL SIGNATURE <u>Everett C. Sutter</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Everett C. Sutter MD</u>				<u>Dames Quarter, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-22-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Vernon Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Mt Vernon Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Becker McQuest</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>OCT 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11742

## CERTIFICATE OF DEATH

11735

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>6 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D.</b>		d. STREET ADDRESS <b>R.F.D.</b>	
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>WRIGHT</b> Last <b>TULL</b>		4. DATE OF DEATH Month <b>October</b> Day <b>20</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 24, 1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>James Wright</b>		14. MOTHER'S MAIDEN NAME <b>Annie Strudwick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. E. Marie Tull—R.F.D. Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tytic Myocarditis</b> DUE TO <b>Inanition</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. <b>Due to hypostasis of right upper abdomen with</b> DUE TO <b>Distension of right lower O. obstruction</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension. Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 mo</b> <b>6 mo</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/19</b> , 19 <b>58</b> , to <b>10/20</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10/2</b> , 19 <b>58</b> , and that death occurred at <b>4:16 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. N. Barr, M.D.</b>		ADDRESS (Street, city or town, state) <b>Crisfield, Md.</b> DATE SIGNED <b>10/20/58</b>	
PHYSICIAN'S NAME (Type) <b>A. N. Barr, M. D.</b>		Main St., Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 22, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Song—Crisfield, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>OCT 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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11743

## CERTIFICATE OF DEATH

11736

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>SOMERSET</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deal Island</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deal Island</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>				1. d. STREET ADDRESS <u>Main Road.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JANIE</u> Middle <u>WALTERS</u> Last <u>WALTERS</u>				4. DATE OF DEATH Month <u>OCT.</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 30 - 1874</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Household duties</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Household</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GUSTAVUS SOMERS</u>				14. MOTHER'S MAIDEN NAME <u>MARY BENTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>FAULINE MASON</u> Address <u>Deal Island Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Bronchitis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Chronic Arthritis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 15<sup>th</sup> 1954</u> to <u>Oct 17<sup>th</sup> 1958</u> , that I last saw the deceased alive on <u>Oct 17 1958</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Princess Anne Md</u> DATE SIGNED <u>10.18.58</u>							
ACTUAL SIGNATURE <u>Eldon G. Marksman M.D.</u>				PHYSICIAN'S NAME (Type) <u>Eldon G. Marksman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct 19 - 1958</u>		<u>ST. JOHNS</u>		<u>Deal Island Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. G. Webster</u> ADDRESS <u>Deal Island Md</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 27 '58</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES E. WALTERS		SEX Male	
AGE 35		RACE White	
DATE OF DEATH OCT 10 1943		PLACE OF DEATH Baltimore, Md.	
TIME OF DEATH 10:30 AM		CAUSE OF DEATH Myocardial Infarction	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk	
MARITAL STATUS Single		EDUCATION High School Graduate	
RELIGION Catholic		SERVICE None	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause of death. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland.

The Registrar of the Department of Health, Baltimore, Maryland, is to be notified of the death of every person who dies in this State, and is to be furnished with a copy of this certificate.

The Registrar of the Department of Health, Baltimore, Maryland, is to be notified of the death of every person who dies in this State, and is to be furnished with a copy of this certificate.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11737

11729

Item 7 Film G235 11-18-58 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home on Paper Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Wicks</u> Last <u>Wicks</u>		4. DATE OF DEATH <u>Body Found 22 Oct. 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 7, 1907</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafarer</u>		12. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
13. BIRTHPLACE (State or foreign country) <u>Newberry, S.C.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>Thomas Long</u>		16. MOTHER'S MAIDEN NAME <u>Louise Mason</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. <u>  </u>	
19. INFORMATION <u>LULAMAF PARK, N.C.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>982x</u> DUE TO <u>Fractured Skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lacerated Scalp</u> (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lacerated Scalp Fractured Skull With Sharp Instrument</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> Minute <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Wm H. Houlbourn</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Wm H. Houlbourn M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Oct 23-1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 24 '58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ward's Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Marion Sta. Som. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Stark</u>		ADDRESS <u>Marion Sta., Md.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

CHRISTIAN STATE DEPARTMENT OF HEALTH - BIRMINGHAM  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
 11-17-1927

Name Thomas Long	Date of Birth 1870	Sex Male	Race White
Residence Newberry, S.C. U.S.A.	Date of Death Oct. 1, 1927	Cause of Death Heart failure	Place of Death Home on paper street
Name of Physician Lillian	Name of Medical Examiner Wicks	Name of Coroner Christie	Name of Undertaker Wicks
Name of Burial Place Thomas Long	Name of Burial Place Thomas Long	Name of Burial Place Thomas Long	Name of Burial Place Thomas Long

I hereby certify that the above is a true and correct copy of the original record of the death of the above named person.

Signed: \_\_\_\_\_  
 Medical Examiner

Signed: \_\_\_\_\_  
 Coroner

Signed: \_\_\_\_\_  
 Undertaker

Signed: \_\_\_\_\_  
 Burial Place